HOUSE BILL 962
By Sherrell

SENATE BILL 1296

By Pody

AN ACT to amend Tennessee Code Annotated, Title 4; Title 5; Title 6; Title 7; Title 33; Title 56; Title 63; Title 67 and Title 68, relative to health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part:

56-7-3501. As used in this part:

(1) "Allowed amount" means the contractually agreed upon amount paid by a carrier to a healthcare entity participating in the carrier's network;

(2) "Commissioner" means the commissioner of commerce and insurance;

(3) "Comparable healthcare service" means any covered non-emergency healthcare service or bundle of services;

(4) "Health plan" means health insurance coverage as defined in § 56-7-109;

(5) "Healthcare entity" means:

(A) Any healthcare facility licensed under title 33 or 68; and

(B) Any healthcare provider licensed under title 63 or 68; and

(6) "Insurance carrier" or "carrier" means a health insurance entity as defined in § 56-7-109.

56-7-3502.

(a) Beginning upon approval of the next health insurance rate filing on or after January 1, 2020, a carrier offering a health plan in this state shall comply with this section.

(b) A carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the carrier information on the payments made by the carrier to network entities or providers for comparable healthcare services, as well as quality data for those providers, to the extent available. The interactive mechanism must allow an enrollee seeking information about the cost of a particular healthcare service to compare allowed amounts among network providers, estimate out-of-pocket costs applicable to that enrollee's health plan, and the average paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one (1) year. The out-of-pocket estimate must provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit from a carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made. A carrier may contract with a third-party vendor to satisfy the requirements of this subsection (b).

(c) Nothing in this section prohibits a carrier from imposing cost-sharing requirements disclosed in the enrollee's policy, contract, or certificate of coverage for unforeseen healthcare services that arise out of the non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(d) A carrier shall notify an enrollee that the provided costs are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

56-7-3503.

(a) If a patient or prospective patient is covered by insurance, a healthcare entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide within two (2) working days, based on the information available to the

healthcare entity at the time of the request, sufficient information regarding the proposed non-emergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from the patient's insurance carrier to identify out-of-pocket costs, which could be through an applicable toll-free telephone number or website. A healthcare entity may assist a patient or prospective patient in using a carrier's toll-free number and website.

(b) If a healthcare entity is unable to quote a specific amount under subsection (a) in advance due to the healthcare entity's inability to predict the specific treatment or diagnostic code, the healthcare entity shall disclose what is known for the estimated amount for a proposed non-emergency admission, procedure, or service, including the amount for any facility fees required. A healthcare entity must disclose the incomplete nature of the estimate and inform the patient or prospective patient of their ability to obtain an updated estimate once additional information is determined.

(c) Prior to a non-emergency admission, procedure, or service and upon request by a patient or prospective patient, a healthcare entity outside the patient's or prospective patient's insurer network shall, within two (2) working days, disclose the price that will be charged for the non-emergency admission, procedure, or service, including the amount for any facility fees required.

(d) Healthcare entities shall post in a visible area notification of the patient's ability, for those with individual or small group health insurance, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow an insurance carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for the patient's care to different providers for similar services. This notification must inform patients of their right to obtain services from different providers regardless of a referral or

recommendation from the provider at the healthcare entity, and that seeing a high-value provider, either their currently referred provider or a different provider, may result in an incentive to the patients if they follow the steps set by their insurance carrier. The notification must give an outline of the parameters of potential incentives approved in this part. The notification must also inform patients that their carrier is required to provide enrollees an estimate of out-of-pocket costs and contracted amounts paid for their care to different providers for similar services via a toll-free telephone number and healthcare price transparency tool. A healthcare entity may provide additional information in any form to patients that inform them of carrier specific price transparency tools or toll-free phone numbers.

56-7-3504. The commissioner is authorized to promulgate rules as necessary to implement this part. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. For purposes of promulgating rules, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect January 1, 2020, the public welfare requiring it, and shall apply to all health plans entered into, amended, or renewed on or after that date.